Employer Compliance Alert

Garner Insurance Services

AGENCIES ISSUE INTERIM GUIDANCE ON EXTERNAL REVIEW PROCEDURES

When the agencies responsible for administering the new claims and appeals procedures mandated under the Affordable Care Act issued their first round of guidance on this subject (as summarized in our August 2010 article), they noted that additional guidance on the Act's new external review procedures would be coming out soon. That guidance has now been issued. It includes the following elements:

- Interim guidance for conducting external reviews by insured health plans;
- Interim procedures to be followed by self-funded, ERISA plans; and
- Model notices to be used in communicating denials after both internal and external reviews.

Note that none of these new claims and appeals procedures will apply to "grandfathered" plans. The standards to be followed in preserving a plan's grandfathered status were outlined in our June 2010 article.

Interim Guidelines for Insured Plans

As explained in the agencies' earlier guidance, an insured plan must comply with either a state's external review procedures (if any) or with federal standards that have yet to be determined. The Department of Health and Human Services (HHS) will be posting those federal standards on its website in the near future. In the case of an insured plan, the insurance carrier has the primary responsibility for complying with these external review standards.

Interim Procedures for Self-Funded Plans

During an interim period (commencing with the first plan year beginning on or after September 23, 2010, and ending when future guidance is issued), non-grandfathered, self-funded ERISA plans have two options for complying with this new external review requirement. First, they may voluntarily comply with a state's external review procedures (assuming a state makes those procedures available to self-funded plans). Alternatively, they may implement procedures outlined by the Department of Labor (DOL) in its Technical Release 2010-01.

These procedures are based on the "Uniform Health Carrier External Review Model Act," as promulgated by the National Association of Insurance Commissioners. They allow a claimant to request an external review after the denial of an internal appeal. Moreover, if the requirements for an *expedited* external review are satisfied, such a review may be available after the denial of a *claim*. Although plans must *offer* this external review option, a claimant need not take advantage of the option before seeking judicial review.

The Technical Release describes somewhat different procedures for "standard" and "expedited" external reviews. In general, an expedited external review is available if a claimant's medical condition is such that the timeframes for either an internal appeal of a denied claim or a standard external review would seriously jeopardize the claimant's life, health, or ability to regain maximum function. Not surprisingly, the timeframes for taking action under an expedited external review are generally shorter than those that apply to a standard external review.

Standard External Review Procedures

A claimant must be given up to four months to request an external review of the denial of an internal appeal. Once a plan receives such a request, it has only five days in which to determine whether an external review is available to the claimant and, if so, whether the claimant's request for such a review is complete. After making that determination, the plan has only *one* day in which to notify the claimant if an external review is not available or if the request is incomplete.

If a request for an external review is complete (and the claimant is entitled to exercise that option), the plan must promptly assign the request to an accredited independent review organization (IRO). Moreover, to avoid bias and assure independence of the IRO, a plan must contract with at least three different IROs. Requests for external reviews must then be assigned to these IROs either randomly or on a rotating basis.

Within five days after assigning a request to an IRO, the plan must provide the IRO with all of the documents and information the plan considered in denying the claim or appeal. If a plan fails to meet this deadline, the IRO may terminate the external review and simply reverse the plan's decision. For this reason, a plan's timely submission of documents and information will be vital.

The IRO must then act in accordance with the terms of its agreement with the plan. The Technical Release spells out a number of provisions that must be incorporated into such an agreement. For instance, an IRO must notify the claimant within ten business days of receiving a request for review, must promptly forward to the plan any additional information submitted by the claimant, and must notify both the claimant and the plan of the IRO's final decision within 45 days of receiving the request for review.

If an IRO reverses a plan's decision, the plan must *immediately* provide the requested coverage or pay the claims at issue.

Expedited External Review Procedures

Should the circumstances entitle a claimant to an "expedited" external review, that review may take place contemporaneously with any internal appeal. Upon receiving a request for an expedited external review, a plan must "immediately" determine whether the request meets the standards for such a review and then "immediately" notify the claimant of its determination on this point.

If the request is eligible for expedited review, the plan must transmit all of the necessary documents and information to the IRO "electronically or by telephone or facsimile or any other available expeditious method." The IRO must then make its determination "as expeditiously as the claimant's medical condition or circumstances require, but in no event more than seventy-two hours after the IRO receives the request for an expedited external review."

Model Notices

As a part of this recent guidance, the agencies responsible for administering these procedures have also issued three different model notices. These are captioned as follows:

- Model Notice of Adverse Benefit Determination
- Model Notice of Final Internal Adverse Benefit Determination
- Model Notice of Final External Review Decision

Plans and insurers may want to start using these model notices. In any event, they should probably modify any notices currently in use to ensure that they provide all of the information contained in these models.

The agencies also note that they will soon be issuing model language to be inserted into summary plan descriptions as a way of describing both the new internal claims and appeals procedures and the external review procedures addressed in this latest guidance. That model language will be posted on both the DOL and HHS websites. Non-grandfathered plans that are subject to these new rules will want to watch for this language and then incorporate it into their SPDs by the time the new rules take effect.

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